Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DAVID WOOD, MD

Respondent Name
BITCO GENERAL INSURANCE CORP

MFDR Tracking Number
M4-18-0448-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This drug code reimbursement is generally based on Medicare rates. Medicare allows $38.40 for Code A9579."

Amount in Dispute: $38.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT code A9579 was denied on both EORs. The payment that was being requested has already been included in another service procedure occurring that day, which is one of the reasons why the carrier has included the CMS-1500 under CPT code 70553."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2017	Code A9579 (20 Units)	$38.40	$38.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care would be fair and reasonable.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P14-payment is included in another svc/procdre occurring on same day.
   - RP3-CMS statutory exclusion/svc not paid to physicians.

- W3-Appeal/Reconsideration

Issues

1. What is the applicable fee guideline for professional services?
2. Is the allowance for code A9579 included in the allowance of code 70553? Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   A review of the submitted billing finds that the requestor billed for CPT codes A9579 and 70553 on the disputed date of service. The descriptions of these codes are:

   - A9579- "Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (nos), per ml."
   - 70553-"Magnetic resonance (eg, proton) imaging, brain (including brain stem)."

   Per CMS Billing and Coding Guidelines for Magnetic Resonance Imaging policy, "As of 01/01/2007, a separate payment is made for contrast medium used in performing all MRI or MRA services…MRI procedure codes (70549, 70553, 70559, 71552, 72197, 73220, 73223, 73720, 73723, and 74183) include a MRI sequence performed **without** contrast media, followed by a MRI sequence performed **with** contrast media, and followed by MRI **further sequences**. The contrast medium used may be billed separately. No addition payment is made by Medicare for the MRI procedure performed in the **further sequences** phase. The above listed procedures should be reported only once per day."

   According to CCI edits, code A9579 is not a component of code 70553; therefore, the respondent's denial is not supported. As a result reimbursement is recommended for code A9579.

   Per 28 Texas Administrative Code §134.203(d)(1)(2), HCPCS code A9579 does not have a fee schedule in DMEPOS or Texas Medicaid. The Division refers to 28 Texas Administrative Code §134.203(d)(3) which states "if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   28 Texas Administrative Code §134.203(f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in

establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

A review of the submitted report finds the following:

- The requestor is seeking reimbursement of $38.40 for code A9579.
- Code A9579's code descriptor indicates the contrast agent is billed per ml.
- The MRI report indicates "20 ML of Magnevist intravenously."
- The requestor billed for 20 units.
- The requestor submitted an invoice from McKesson that indicates a cost of $710.60 for "Magnevist Vial 20ML."
- The requestor is seeking a lesser amount of $38.40 for code A9579. As such reimbursement of $38.40 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $38.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $38.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/14/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.